Department of Veterans Affairs

Prevention Notes

Update on Evidence-Based Health Promotion and Disease Prevention

There are a number of reviews on evidence of effective health promotion and disease prevention interventions. Two of these are the *Cochrane Library* produced by the Cochrane Collaboration and the *Guide to Community Preventive Services* produced by the Task Force on Community Preventive Services.

The Cochrane Library is a repository of systematic reviews of evidence for effectiveness of interventions including those which prevent disease and promote health. Although all of the reviews in the library are not directly relevant to our veteran population, many of them do address health promotion and disease prevention interventions which may potentially be of benefit to veterans. Recent additions to the Cochrane Library addressing health promotion and disease prevention interventions which are relevant to the veteran population include:

- *'A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of post traumatic stress disorder PTSD';*

  The review concludes that brief psychological debriefing is a useful intervention for prevention of PTSD after traumatic incidents.

- *'Anxiolytics and antidepressants for smoking cessation';*

  The reviewers conclude that there is little evidence that anxiolytics aid smoking cessation. Some antidepressants (bupropion and nortryptyline) can aid smoking cessation.

- *'Hip protectors for preventing hip fractures in the elderly';*

  The reviewers conclude that hip protectors appear to reduce the risk of hip fracture within a selected population at high risk of sustaining a hip fracture. The generalization of this finding beyond high-risk populations is not clear. Acceptability of the protectors to the users remains a problem due to practicality and discomfort.

- *'Carotid endarterectomy for symptomatic carotid stenosis';*

  The reviewers conclude that carotid endarterectomy reduces the risk for disabling stroke or death for persons with ECST (European Carotid Surgery Trialists' Collaborative Group) measured at 70% or NASCET (North American Symptomatic Carotid Endarterectomy Trial Collaborators) measured at 50%. This conclusion is generalizable only to surgically fit patients operated on by surgeons with low complication rates.

Further information on these reviews is available from the *Cochrane Library*, which is available by subscription either in CD-ROM or electronic format at <http://www.cochrane.org>.

The Task Force on Community Preventive Services is developing the *Guide to Community Preventive Services*. The Task Force is supported by the U.S. Department of Health and Human Services (DHSS) in collaboration with public and private partners. The Centers for Disease Control and Prevention provides staff support to the Task Force.

Improving Vaccination Coverage in Adults

The first chapter of the *Guide to Community Preventive Services* looks at the evidence for interventions which improves vaccination coverage in adults. The vaccinations for adults reviewed were tetanus-diphtheria toxoid – 1 dose every 10 years, annual influenza vaccination and once in a lifetime pneumococcal vaccination. The following is a summary of the interventions for which there was evidence of effectiveness.

- Clinical reminder and recall systems are strongly recommended. There is evidence that these improve vaccination coverage in adults. Delivery techniques including telephone calls and mailings are effective in individual practice settings and across communities.
- Multicomponent interventions, which include education, are strongly recommended. Education of both target populations and providers improves vaccination rates.
- Reduction of out-of-pocket costs including provision of free vaccinations or providing insurance coverage for vaccinations increases vaccination coverage.
- Expanded access to vaccination in medical or public health clinical settings increases vaccination rates when the following are implemented: reduction in the distance from the clinical setting to the target population; expanded or more appropriate hours during which vaccination is delivered; delivery of vaccina-

Continued on page 3

Inside this issue . . .

Fall 1999 Vol. 4 #3

National Center For NCHP HEALTH PROMOTION

Editor's Jottings

Autumn Greetings! We hope you find this issue brimming with helpful information. From the column written by our new Acting Director, Dr. Verona Hegarty, to the feature article on the Office of Special Projects, VHA, to an update on shared decision-making, to the recent report concerning the practice of complementary and alternative medicine in the VHA, to the final results of the Veterans Health Survey. Our goal throughout is to keep you informed of current program developments in health promotion and disease prevention.

PMFAG Meeting Highlights

The Preventive Medicine Field Advisory Group convened in Durham on July 6 and 7, with Dr. Lois Katz, Chair of the Group presiding. Members in attendance included Dr. Ellen Yee, Dr. David R. Reagan, Dr. Anne Joseph, Rose Mary Pries, Dr. Robert Sullivan and Mildred Eichinger. Several members of the NCHP staff also attended the meeting.

Administrative Changes: Headquarters and NCHP

Dr. Robert T. Frame, DMD, Assistant Undersecretary for Dentistry has been appointed Acting Chief Consultant for the Office of Primary/Ambulatory Care. He succeeds Dr. Ronald Gebhart who has become the new Chief of Staff at the Salt Lake City VA. Recruitment for the position of Chief Consultant, Office of Primary/Ambulatory Care is currently underway.

The National Center for Health Promotion bade a fond farewell to Dr. Robert J. Sullivan, Jr., in early July. Dr. Sullivan's dedicated leadership at the Center over the past four years was recognized by members of the Preventive Medicine Field Advisory Group (PMFAG), Durham VAMC management, National Center for Health Promotion (NCHP) staff and staff from the VHA Office of Primary/Ambulatory Care. Dr. Thomas Holohan, Chief Patient Care Services Officer, presented Dr. Sullivan with a certificate of appreciation. Members of the PMFAG and NCHP staff demonstrated their gratitude for Dr. Sullivan's contributions to the National Center by presenting him with gifts. Dr. Verona Hegarty assumed the role of Acting Director of the National Center for Health Promotion on July 13th. Recruitment for the position of Director of the NCHP is underway.

Dr. Laurence G. Branch has moved from the National Center for Health Promotion to full-time research Professor at Duke University, Center on Aging and Human Development.

VHA Handbook 1120.2

The two web sites where you can download your copy of the *Handbook 1120.2* are: www.va.gov/publ/direc/health on the Internet and <vaww.va.gov/publ/direc/health> on the Intranet. You may access the *Handbook* by visiting either the NCHP home page at <www.va.gov/nchp>or <vaww.va.gov/nchp> respectively. It can be retrieved as well through the VA Homepage at <www.va.gov> (click on Special Programs, this will bring up the NCHP home page; then click on Publications). The *Handbook* emphasizes evidence-based interventions in preventive medicine. An introductory table relates the origin of the recommendations. The annual facility report has been eliminated. The *Handbook* was distributed to every VAMC. Contact your Publications Control Officer (PCO) or your medical library for a copy.

Veterans Health Survey (VHS)

The third successive year's report was distributed in July to facilities and VISNs (see related article on p. 3). NCHP will attempt to publicize the VHS to Veterans Service Organizations (VSOs). Two publications by NCHP staff related to the Survey are in preparation and two are in press.

The PMFAG meeting was followed by the convening of the planning committee for the national prevention conference to be held in the third quarter of FY 2000. (see announcement p. 8)

National Prevention Conference

Plans are underway for a national prevention conference to be held April 11 - 13, 2000. Program updates will be made periodically to the Patient Health Educators, the Preventive Medicine Program Coordinators and the VISN Prevention Network Coordinators.

In preparing the agenda and goals of the meeting the Preventive Medicine Field Advisory Group members contacted VISN Clinical Managers in the 22 networks and asked them to identify practical subjects of interest to their primary care clinicians. The program agenda is being developed from the information received from the field.

The goal of the conference will be to present "best practices" for the delivery of preventive services. *VHA Handbook 1120.2* will be explained and "successful strategies" or intervention models integrated with VHA policy including the Prevention Index (PI), the Chronic Disease Index (CDI) and clinical guidelines. Emerging VA partnerships, e.g., Institute for Healthcare Improvement and Robert Wood Johnson initiatives on chronic disease, diabetes and congestive heart failure (CHF) management will be explained. Other topics to be discussed include prioritizing programs, conducting health risk profile assessments, educational strategies for promoting shared decision-making, update on evidence-based prevention research, successful networking skills, effective counseling techniques, achieving behavior change in patients and advanced directives. Time for network and local planning will also be built into the program.

Planning Committee Members are: Mary Burdick, NCHP, Mildred Eichinger, Primary/Ambulatory Care, Headquarters, Joseph Francis, VISN 9, Dorothy Gagnier, NCHP, Verona Hegarty, NCHP, Lois Katz, VA New York Harbor Health Care System, Marilyn Peters, VA Greater Los Angeles Health Care System, Rose Mary Pries, Employee Education System – St. Louis Campus and David R. Reagan, VAMC Johnson City, TN. We would like to hear your ideas regarding the format and content of the anticipated program. Please contact Dr. Gagnier at 919.416.5880 x 226 or via Microsoft Exchange or the Internet, <gagni001@mc.duke.edu>.

Collection of Education Materials

Your facility should have been contacted by now by the NCHP staff who are working to have NCHP serve as a resource for the field in patient education health promotion and disease prevention. We are soliciting education materials in the form of printed materials (flyers, brochures, etc.), classes (outline, handouts), individual instruction and counseling, computer assisted instruction (CAI), and audio visual products such as videos, CDs and films. We are particularly interested in those materials that have been developed "in-house" and are asking that lists only be made of the vendors' names whose materials are used. These include agencies such as the American Heart Association (AHA) and the American Cancer Institute (ACI), etc. as well as companies. It is not necessary to provide us with samples of the audio visual materials, simply name and describe them.

The goal of the project is to 1) facilitate sharing of information between facilities; 2) identify areas where a shortage exists; and 3) collaborate with other groups both within and outside of the VHA in developing education materials that are not currently available to veterans.

We would like information pertaining to the preventive services cited in the *VHA Handbook 1120.2*. These are: hypertension detection, hyperlipidemia detection, influenza immunization, pneumococcal immunization, tetanus and diphtheria immunization, tobacco use screening and counseling, problem drinking and alcohol moderation, weight control and nutrition counseling, physical activity counseling, seatbelt and accident avoidance counseling, dental health counseling, HIV infection and sexual disease counseling, contraception counseling, screening for rubella susceptibility, hormone replacement counseling, screening for visual loss, screening for hearing loss, cervical cancer detection, breast cancer detection, colorectal cancer detection, and prostate cancer counseling regarding screening tests. We are especially interested in materials that have been developed 'in-house' and would only need a single copy of each.

Continued on page 3

Update on Disease Prevention

Continued from page 1

tion in multiple clinical settings including to inpatients; and, reduced administrative barriers within clinics, e.g. drop-in clinics. The evidence indicates that expanding access is effective in increasing vaccination coverage as part of a multi-component intervention. There is insufficient evidence that expanded access alone increases vaccination coverage. However, "insufficient evidence" per se, does not indicate evidence of ineffectiveness. Rather, "insufficient evidence" indicates small numbers of studies performed and variability in interventions studied.

- Home visits involving provision of face-to-face services in the recipient's home including assessment of need for vaccination, referral for vaccination and provision of vaccination in the home setting increase vaccination coverage among adults.
- Interventions which lead to an increase in vaccination coverage and which are aimed specifically at providers include provider reminder and recall systems, and feedback to providers on vaccination rates. In addition, standing orders authorizing nonphysician medical personnel to prescribe and deliver vaccinations by protocol, without direct physician involvement at the time of intervention, increase vaccination coverage in the clinic, hospital and nursing home setting.

Further information on improving vaccination coverage is available in hard copy format in the *Morbidity and Mortality Weekly Report*, June 18, 1999/Vol. 48/No. RR-8 and in electronic format on CDC's website at <http://www.cdc.gov>.

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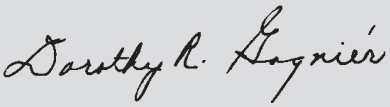
Acting Director
National Center for Health Promotion and Disease Prevention

Editor's Jottings

Continued from page 2

To date we have received information about the printed materials being used but very little related to other kinds of educational interventions such as classes held, individual counseling provided, computer assisted instruction or audio visuals. If you have information on any of these materials, even if you have already submitted other kinds of information, please forward it to us. Materials should be sent to **Dorothy R. Gagnier, Ph.D., Assistant Director, Education, National Center for Health Promotion (NCHP), 508 Fulton Street, Durham, NC 27705**.

We are always looking for information to share with the field. Please consider writing an article for *Prevention Notes*. Articles can be sent on diskette (include a hard copy), or by e-mail to Dorothy R. Gagnier, Ph.D., on Microsoft Exchange or via the Internet at gagni001@mc.duke.edu



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1999 Veterans Health Survey

One of the responsibilities of the VHA National Center for Health Promotion (NCHP) is an annual report to Congress on the rates that veterans who receive care at our Veterans Health Administration facilities receive health promotion and disease prevention services. The current list of services in *VHA Handbook 1120.2* includes 13 evidence-based services that are recommended for all average risk veterans receiving primary care at VHA facilities.

The recommended intervals for receipt of services are for normal or average risk individuals. Any veteran with an elevated risk due to family history, concurrent diseases, lifestyle, or other reasons may require more frequent services.

Results of the 1999 Veterans Health Survey

Random samples were drawn of 320 men and 160 women visiting primary care clinics in all 148 VHA facilities in the United States during FY 1998 (six sites did not have 160 women eligible; we selected all who were eligible in those instances). Eligibility was defined as living in the community with a post office address and having received primary care at least once during fiscal year 1998 from any of these clinics: General Internal Medicine (301), Geriatric Clinic (318), Geriatric Evaluation and Management Clinic (319), Women's Clinic (322), and the Primary Care/Medicine Clinic (323). We achieved a 67% adjusted response rate after two mailings (45,037 respondents in total ÷ 70,770 – 3,230 ineligibles). The data were optically scanned into a computer and 100% verified on screen.

Based on these responses, we calculated rates for each of the 13 prevention services for each VAMC, and the weighted averages for VISNs and the VHA as a whole. We also compared these rates with comparable data from the 1997 and 1998 Veterans Health Surveys. The VHA data follow (see page 4).

For the VHA as a whole, both male and female veterans currently exceed the *Healthy People 2000 Goals* in six areas (hyperlipidemia screening, influenza immunization, pneumococcal immunization, colon cancer screening, tobacco counseling, and activity counseling) and the female veterans exceeded the *Healthy People 2000 Goals* in four additional areas (Td boosters, cervical cancer screening, breast cancer screening, and seatbelt use). The preventive practice most in need of attention continues to be counseling for problem drinking and alcohol moderation.

The most dramatic advance in preventive practice since the 1998 survey has come in the area of pneumococcal immunization where the rate for men has increased from 68% to 73% and for women from 71% to 77%. Another significant advance was in the area of colon cancer screening, with the rate for men increasing from 56% to 61% and that for women from 51% to 55%. Current tobacco use dropped 3% for men and 2% for women, a further welcome development.

Laurence G. Branch, Associate Director, NCHP
David W. Brown, Program Associate, NCHP
National Center for Health Promotion and Disease Prevention

1999 Veterans Health Survey

	Healthy People 2000 Goals	VHA Rate[a] 1997 (max n = 44,304)	VHA Rate[a] 1998 (max n = 42,625)	VHA Rate[a] 1999 (max n = 45,037)	Change from 1998 to 1999
PRIMARY PREVENTION (AVOIDANCE)					
1. HYPERTENSION					
% males with blood pressure check in the past 2 years	90%	88%	88%	87%	-1%
% females with blood pressure check in the past 2 years	90%	87%	87%	86%	-1%
2. HYPERLIPIDEMIA					
% males age 35 to 65 with cholesterol checked in the past 5 years	75%	**79%**	**82%**	**83%**	**+1%**
% females age 45 to 65 with cholesterol checked in the past 5 years	75%	**82%**	**85%**	**84%**	-1%
3. INFLUENZA IMMUNIZATION					
% male age 65 and older who received an influenza vaccine this year	60%	**75%**	**77%**	**77%**	0%
% female age 65 and older who received an influenza vaccine this year	60%	**73%**	**74%**	**72%**	-2%
4. PNEUMOCOCCAL VACCINE					
% males age 65+ who received pneumococcal vaccine at least once	60%	59%	**68%**	**73%**	**+5%**
% females age 65+ who received pneumococcal vaccine at least once	60%	**65%**	**71%**	**77%**	**+6%**
5. TETANUS					
% of males receiving Td booster at least once in the past decade	62%	53%	52%	55%	**+3%**
% of females receiving Td booster at least once in the past decade	62%	59%	**62%**	**63%**	**+1%**
SECONDARY PREVENTION (EARLY DETECTION AND TREATMENT)					
6. CERVICAL CANCER DETECTION					
% females under age 65 with Pap test in the past 3 years	85%	**89%**	**89%**	**87%**	-2%
7. BREAST CANCER DETECTION					
% women age 50-69 who received a mammogram in the past 2 years	60%	**85%**	**87%**	**86%**	-1%
8. COLORECTAL CANCER DETECTION					
% males over age 50 receiving a fecal occult blood test this year	50%	33%[b]	**56%[b]**	**61%[b]**	**+5%[b]**
% females over age 50 receiving a fecal occult blood test this year	50%	29%[b]	**51%[b]**	**55%[b]**	**+4%[b]**
ASSESSMENT AND COUNSELING, if appropriate, for:					
9. TOBACCO USE COUNSELING					
% males who are current tobacco users	15%	30%	30%	27%	**-3%**
% females who are current tobacco users	15%	27%	27%	25%	**-2%**
% male tobacco users offered counseling	75%	73%	**79%**	**79%**	0%
% female tobacco users offered counseling	75%	**78%**	**82%**	**84%**	**+2%**
10. PROBLEM DRINKING/ALCOHOL MODERATION COUNSELING					
% males asked/screened for problem drinking/alcohol use this year	75%	29%	39%	38%	-1%
% females asked/screened for problem drinking/alcohol use this year	75%	21%	29%	30%	**+1%**
11. WEIGHT CONTROL AND NUTRITION COUNSELING					
% males receiving nutrition counseling this year.	75%	49%	50%	50%	0%
% females receiving nutrition counseling this year.	75%	45%	47%	48%	**+1%**
12. PHYSICAL ACTIVITY COUNSELING					
% males receiving activity counseling this year	50%	**57%**	**60%**	**61%**	**+1%**
% females receiving activity counseling this year	50%	**55%**	**58%**	**59%**	**+1%**
13. SEATBELT/ACCIDENT AVOIDANCE COUNSELING					
% males receiving seatbelt /accident avoidance counseling this year	50%	11%	16%	17%	**+1%**
% females receiving seatbelt /accident avoidance counseling this year	50%	10%	15%	17%	**+2%**
% males reporting “almost always” using seatbelts	85%	70%	72%	74%	**+2%**
% females reporting “almost always” using seatbelts	85%	**85%**	**86%**	**88%**	**+2%**

a. Weighted as appropriate; 95% confidence interval for the VHA is less than $\pm$ 1.4 %.

b. 1997 figures measure fecal occult blood test in last year; 1998 and 1999 figures also include sigmoidoscopy within last five years.

Lessons Learned: VA Virtual Learning Center

Ever feel like someone must have already solved a problem that you are facing? Ever wonder how many times the VA must figure out how to solve the same challenge over and over at hundreds of medical centers and clinics? Ever wish you had more money and time? If so, the VA Virtual Learning Center may have something for you.

Dr. Garthwaite, Acting Under Secretary for Health, saw that solutions to the everyday challenges were reinvented over and over across the country, when the money and time could be put to better use. He charged the Office of Special Projects to work with the field to develop a way to systematically share the informal knowledge of the VA; to find a way to fix problems once and have the solution available to everyone for them to adapt/adopt. This is the information they never teach you in a class – this is what people figure out on the job to make things work better, to deliver lower cost or better quality or faster service to veterans. Now these innovations are available to all VA employees on the Intranet at <http://vaww.va.gov/vlc.htm> and world wide at <http://www.va.gov/vlc>.

You can share your innovations by clicking on *Submit Lessons* at either web site. In addition, we know you are busy, so the VLC has a feature called *Personal Profile* (click on *Personalize Your Information* and follow the instructions). *Personal Profile* allows you to select the key words of interest to you and every time a new innovation is entered in the Virtual Learning Center with a key word you have selected, you get a one-liner in your e-mail with a hot link directly to that new innovation. This feature brings the innovations to you, rather than making you go hunt down the new ideas of interest to you since your last visit to the VLC. This is the most popular feature of the Virtual Learning Center, with over 111 people signing up for it at the VA Information Technology Conference in August. Innovations are on a broad range of subjects, such as: reducing wait time for clinic appointments, preventing medication errors, creative volunteer programs, cost saving ideas, wellness and health promotion, etc. Check out the key words on the *Search* button or in *Personal Profile*.

Ever want to ask a question of your peers, but were hesitant to ask because someone may think you should already know the answer? The Virtual Learning Center lets you ask questions anonymously through the *Ask Colleagues* feature. The premise is that there are no dumb questions, and odds are, if you don't know the answer, others don't know either. By posting the questions for all to see, others can learn. By making this feature anonymous, the fear is removed that could be present using e-mail or the phone to seek answers. By posting the questions, anyone can share their knowledge. You don't have to be "the" expert to answer a question. Would you visit *Ask Colleagues* and browse the questions – perhaps you could share your insights with someone who is genuinely seeking your ideas?

The innovations can be brought to your desk via *Personal Profile* or you may prefer to *Browse* or *Search* the existing database. *Personal Profile* will only bring you the new innovations released after you sign up. To see which of the approximately 400 innovations which are currently in the database may be of interest to you, click on *Search* and select a key word of interest and hit "GO." Perhaps you want to know what other innovations have been submitted from your facility, then select your facility and hit "GO." Some people prefer to just browse the innovations in an alphabetical list. Each innovation listed under the *Browse* button has a brief core message displayed. If the innovation is of interest, just click on the link and it will take you to the lesson. Whenever a lesson is displayed, it is first displayed in its short version. To see the full lesson click on the "+" sign at the top or bottom of the lesson.

Two new features have been added to the Virtual Learning Center this summer: *Communities of Practice* and *Implementation of Lessons*. *Communities of Practice* (COPs) are groups of experts who interact in a virtual environment to further their knowledge and their field of expertise. The first COPs are:

- Education Leaders
- Data Quality – Employee Education, Training, and Communication
- Self-proclaimed Gurus of Innovation
- VBA Team Development
- VBA Technical Skills
- VHA Clinical Practice Guidelines – Implementation and Education
- VHA Patient Safety

Perhaps there is a need for a COP on Prevention and Wellness? If you are interested, contact Laura Warfield.

Implementation of Lessons is a feature that allows any employee to indicate that they have implemented an idea from the Virtual Learning Center at their site. This can be done either by clicking on the *Implementation of Lessons* feature at the end of any lesson or by clicking on the button on the front page. This provides feedback to the authors regarding how many people found their idea worthy of implementation.

Cash awards are given for the best lesson(s)/innovation(s) in a service/service line which has had 10 or more new innovations submitted in the preceding 12 months. Awards will also be given in other areas in the future, such as: VISN with the most new innovations submitted, Medical Center with the most new innovations submitted, author of lesson with the most implementations recorded, facility implementing the most innovations from the VLC, etc. It is important that we share innovations and that we make use of the existing knowledge capital of the VA.

The Virtual Learning Center became a One VA site this spring, with the addition of the first Veterans Benefits Administration innovations. National Cemetary Administration is also in the process of submitting some of their innovations. The Virtual Learning Center is a Knowledge Management system for the VA, allowing the VA's most valuable asset, what our employees know, to be shared, in an easy, user-friendly way. We invite you to check out the VLC to see if it can save you money and time or make your day a little easier.

Send questions about the VLC to: Laura J. Warfield, Program Manager, 202-745-2200 or laura.warfield@med.va.gov.

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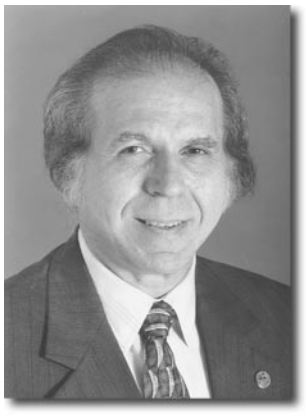

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Complementary & Alternative Medicine Practice in VHA

The Klemm Analysis consultants recently completed a study on Complementary and Alternative Medicine (CAM) within and outside Veterans Health Administration (VHA) for the Under Secretary for Health. The Ambulatory Care Field Advisory Committee, chaired by Dr. Kenneth Klotz of the Indianapolis VAMC, has provided ongoing advice throughout the study. The general methodology for the study included site visits to five VA medical centers looking qualitatively at the kinds of CAM therapies being provided, who was providing them and the knowledge and perceptions of clinicians about CAM. This was followed by a written survey sent through the Network Clinical Managers to 60 individuals in each network. Following completion of the survey, Klemm conducted another five site visits, focusing this time on the opportunities and barriers to implementing CAM. Klemm talked with a total of approximately 75 patients at the 10 sites, obtaining information about their use of CAM therapies and their perceptions about CAM. The consultants also reviewed the current status of CAM throughout the private sector, assessed the extent to which health plans are currently covering CAM services and visited two sites where CAM services are being provided in conjunction with conventional services (integrative medicine). Findings of this study are summarized below.

Over 40% of the American public are utilizing some type of CAM services and judging from the level of use reported by veterans who were interviewed, use among the VA population is similar. The most frequent types of CAM therapies in use by veterans are herbals (plant and plant products, such as Gingko Biloba), biologics (non FDA approved drugs or off-label prescribing) and nutritional products (vitamins, minerals, and various diets). In general, veterans who are using CAM products do not tell their providers what they are taking, as they believe their providers would not approve or are not interested. Educating patients about CAM therapies and products is important, as there appears to be a generalized belief among the general public that CAM therapies and products are "natural" and are, therefore, safe. Patients tend to get their information from their friends and family, what they read (without assessment or understanding of the quality of the publication) and/or sales people in health stores, etc.

The majority of providers do not ask patients about CAM use, frequently because they do not know what to advise. Most providers indicated that they feel a need to have more information about CAM, including information about what therapies are effective and which are not. In general, VA clinicians indicate openness to CAM when there is evidence of effectiveness. They also want information and references that will allow them to talk more knowledgeably with patients about CAM. It should be noted that most pharmacists and dieticians indicate that they do ask patients about CAM therapies they use. They are generally more familiar with the topics within their areas of expertise.

VHA is not currently capturing the CAM therapies patients are utilizing or the workload related to the CAM therapies it is providing. There are potentially serious drug-herbal/biologic interactions, which are not identified or addressed due to the lack of information and data capture, leading to potential serious patient safety issues. There are two large issues related to data. The first is, in general, most providers on intake or at ongoing visits do not capture the use of CAM products and therapies used by patients. This leads to a generalized lack of information in our system about the CAM therapies being utilized by our patients and for what purposes. This absence of even the most basic data is probably the biggest barrier in VHA to CAM research. The second problem related to data is that most of the CAM therapies currently being provided are not captured in VHA workload data.

Other findings related to CAM are communication and variation. Even within the same facility there is a lack of knowledge about CAM services that are being provided. Across facilities there is a wide range of types of services that are being provided. According to the survey of facilities, every single VHA medical center is providing some type of CAM services, though a number of the services that fit under NIH's definition of CAM are considered mainstream medicine by many, e.g., biofeedback, hypnotism, etc. Also, in every facility at least one person who responded to the survey identified CAM services that were being provided routinely while someone else at the same facility said no CAM services were being provided at the facility.

There is growing evidence that some types of CAM therapy are effective for some conditions. For example, there is evidence, supported by two NIH Consensus Conferences assessing the literature, that acupuncture is effective for a number of conditions. There may be some areas where facilities might want to soon consider either providing or allowing practitioners to refer patients for some CAM therapies. For those conditions, such as chronic back pain, where there is an acknowledged lack of effective conventional therapies and soft evidence that certain CAM therapies are effective for some patients, the benefits of providing these services may outweigh the risks and may improve customer satisfaction.

The public is increasingly demanding that various types of CAM services be made available and the market place is responding. Currently, nearly 80% of health plans cover some types of CAM services, though how they make those services available differ markedly. A number of traditional practices are beginning to add CAM services on site to expand patient options and are calling these new entities "integrative medicine practices." Congress is pushing through a number of hearings with Health and Human Services, the Department of Defense, and VA to make CAM services more available.

Look to the next edition of the newsletter to learn more about what VHA plans to do in response to this report. In the meantime if you have questions or comments, feel free to send an e-mail message to Nicheole Amundsen at <nicheole.amundsen@mail.va.gov>.

Nicheole Amundsen
Clinical Program Manager
Primary/Ambulatory Care, VHA Headquarters

Editor's Note: In another sign of the growing acceptance of certain types of alternative medicine, the American Hospital Association in August signed an agreement "to help hospitals and other institutions learn about and develop complementary or alternative medicine programs." AHA says 9 percent of community hospitals have such programs. The agreement...reflects the "growing interest on the part of both patients and practitioners in making therapies such as acupuncture and herbal medicine part of standard medical treatment."

Update on Shared Decision-Making

Shared Decision Making Notice

Shared Decision Making is a critical component of counseling related to preventive medicine. *Veterans Health Administration Notice 99-02* dated June 15, 1999, has been released to the field. It is also available on both the Internet and the Intranet:

Internet: http://www.va.gov/publ/direc/health/

Intranet: http://vaww.va.gov/publ/direc/health/

The Shared Decision Making Notice describes the purpose, background and rationale, goals and examples, and offers selected references. It also provides specific examples of resources which facilities have used to promote shared decision making. The Headquarters Office of Primary and Ambulatory Care sponsored this Notice, and in partnership with the Employee Education System, developed educational packages on shared decision making for clinicians and clinical administrative support staff.

Clinical Providers Education Package

This video and print package is scheduled for release by September 15, 1999 via the designated education contact at each facility. It targets clinical providers and is designed to raise consciousness about the meaning and value of shared decision making. In addition to the brief video, the package contains:

- *VHA Notice 99-02, Shared Decision Making*, dated June 15, 1999
- A "position paper" that offers the evidence-basis for shared decision making, an orientation regarding issues related to shared decision making, and ideas and success stories for effective implementation
- A discussion guide suitable for use in learning situations of varying lengths
- Frequently asked questions
- A reference list

Clinical Administrative Support Staff Education Package

The video and print package targeted for clinical administrative support staff will be distributed by October 15, 1999 via the designated education contact at each facility. Clinic administrative support staff are critical to the efficiency and satisfaction of the patient-provider relationship. For this reason, their support for and involvement in promoting shared decision making is essential. To engage clinic administrative support staff in shared decision making, this brief video and print package can be used to raise their consciousness about shared decision making and their role in helping patients make the best use of their time with clinicians. This package provides some "scripted" text for conversations with patients, frequently asked questions and resources that could be used to answer or refer patient's questions.

Rose Mary Pries, M.S.P.H., CHES
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Employee Education System – St. Louis Center

VHA Hepatitis C Strategic Initiative

Hepatitis C virus (HCV) infection is a serious national problem. The Centers for Disease Control and Prevention estimate that 3.9 million Americans or 1.8 percent of the population are currently infected. The infection kills some eight to 10 thousand people a year, and that number could triple in the next few decades.

Hepatitis C is of particular concern to the Department of Veterans Affairs because of its prevalence in VA's service population. The virus appears to be particularly prevalent among Vietnam veterans. To help address the needs of veterans who are hepatitis C positive, the VA announced in January 1999 it was establishing two Centers of Excellence for Hepatitis C at the Miami and San Francisco medical centers. The two Centers will serve as linchpins in a five-point response to the hepatitis C epidemic that include patient education, health-care provider education, epidemiological assessment, treatment and research. The VA's goal is to provide treatment to all veterans who are appropriate candidates and desire treatment.

The first in a special series of four articles on Hepatitis C infection, and approved for CE credit to pharmacists and nurses entitled "Hepatitis C: From Pathogenesis to Prognosis" was published in the July, 1999 issue of the *Veterans Health System Journal*. The second article, "Diagnostic Techniques and Monitoring Strategies" appeared in the September issue of the same Journal. Visit the VHA hepatitis C web site at <www.vahepatitisc.com>.

For more information about the Centers of Excellence for Hepatitis C contact Julie Currier-Gooden, Senior Nurse Educator at the Miami VAMC, 305.325.7066 or Amy Skerkis, 415.221.4810 x 4407 in San Francisco.

Check out this newsletter on the Web
at the Internet and Intranet addresses listed below!
Internet: www.va.gov/nchp
Intranet: vaww.va.gov/nchp

Preventive Medicine Field Liaison Activities

The preventive medicine coordinator conference calls have been scheduled for the next calendar year. Mark your calendars and note that the call-in numbers are different. Please encourage all others at your site who are interested in preventive medicine to join us on these calls.

Preventive Medicine Field Liaison Conference Call

1:00 to 1:50 Eastern

1/25/2000 Call-in number: (877) 230-4050

5/02/2000 Call-in number: (877) 230-4050

9/12/2000 Call-in number: (800) 767-1750

12/05/2000 Call-in number: (877) 230-4050

Recently, the liaison staff were involved in efforts to identify successful strategies used in the VA for providing evidence-based preventive medicine services to veterans. The NCHP staff used the 1998 Veterans Health Survey and Prevention Index data to identify top performing programs for 13 preventive services recommended by the United States Preventive Services Task Force (detection of hyperlipidemia, hypertension, colorectal, breast, and cervical cancers; pneumococcal, influenza, and tetanus-diphtheria vaccinations; counseling for nutrition, physical activity, seat belts and tobacco use; and, screening for problem drinking and alcohol use). Twelve of the 13 prevention services showed a wide range of scores, suggesting that the high performers have strategies to share that may benefit the low performing sites. Descriptions of prevention strategies used in 22 high performing sites were obtained.

Effective programs used multifaceted approaches but strategies varied according to local resources and levels of maturity of primary care systems. All sites reported that achieving buy-in from clinical staff was critical, as were local means to monitor progress, and clearly identified roles and responsibilities. Progress reviews, clinician education and feedback and delegation to nursing staff were common approaches. Mechanisms to facilitate staffs' and veterans' awareness of individual veterans preventive care needs varied widely. For additional information, you may contact me or review the article. To provide models for health promotion services to emulate, these and other strategies will be highlighted at our Spring 2000 preventive medicine conference.

We, here at the NCHP, are looking for additional ways to help you. The liaison staff initiated contact with Preventive Medicine Program Coordinators to learn the major issues you deal with every day that impede your effectiveness in providing recommended preventive care to each veteran and what could be done that would help you the most. We plan to bring these issues and suggestions for possible solutions to the attention of persons who will be able to address them. Please contact me if I have not yet spoken with you individually.

Burdick MB. Success stories in prevention. *VHSJ* 1999; 4(9)

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National Center for Health Promotion and Disease Prevention

Mark Your Calendars Now!

Prevention and Education Meeting • April 11- 13, 2000

The meeting will be held at the Disneyland and Disneyland Pacific Hotels, Anaheim, CA. Participants for the conference will be selected and funded for travel by the Networks or facilities. The goal of the meeting is to feature"best practices" for the delivery of prevention activities. Join us in Anaheim in the new millenium!

National Center for Health Promotion (NCHP)
Veterans Affairs Medical Center
508 Fulton Street
Durham, NC 27705
Address Correction Requested

Putting Prevention Into Practice in the VA